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ABSTRACT

Licensing is not only ineffective in most professions including the health field but perhaps counterproductive in trying to protect the consumer from incompetent or unethical practitioners. The history and status of professional licensing in this country date back to 1760. Today almost 5,000 different professional and occupational licenses are granted, affecting one-third to one-fifth of the workforce. An examination of the research shows: (1) little evidence that the quality of professional services has improved as a result of licensing laws; (2) the increased cost of services resulting from licensure prevents the poor from being able to afford or find a practitioner; and (3) equally beneficial and cheaper alternatives are available. Recommendations and guidelines put forth to guide the formation of health care regulations emphasize that licensing laws are meant only to protect the public from harm. A system of registration within each state is recommended for the mental health field, including a registration board. (Author/KMF)

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THE EFFECTIVENESS OF LICENSING

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I'd like first to thank the Public Affairs Research Group and the Board of Medical Quality Assurance for inviting me to speak at this colloquium today. Over the years I have been deeply impressed with California's commitment to improving the effectiveness of regulation in general and licensing in particular. The activeness of many of this state's disciplinary boards attests to this, and the very fact that the Board of Medical Quality Assurance is putting on these colloquia suggests that California intends to remain at the forefront in this area.

My own interest in professional regulation stems from a paper I wrote at Harvard Law School on the statutory regulation of encounter group leaders (Hogan, 1972). Subsequently, as a Research Fellow in Harvard's Department of Psychology and Social Relations, I broadened my focus to encompass psychotherapy as well. With a long-term grant from the Falk Medical Fund in Pittsburgh, I studied the history of the professions and their regulation for four years to determine their potential relevance for the mental health field (Hogan, 1979a-d).

My initial conclusion was that psychotherapy, for a variety of reasons, required a vastly different regulatory framework than offered by traditional methods of regulation. In brief, it seems psychotherapy is virtually incapable of adequate definition, at least for licensure purposes. In addition, an overwhelming lack of agreement exists as to what skills are necessary for competent practice or how one should measure those skills, if we knew what they were. In addition, I could find no evidence that traditional academic credentials were even minimally

related to therapeutic competence. Without resolution of these fundamental issues, most political scientists agree that licensing is unlikely to have any positive effect and is inappropriate.

But even more compelling to me was the mounting evidence that licensing was relatively ineffective and perhaps counterproductive in even such highly developed professions as law and medicine. As I looked into these supposedly mature professions, I realized that they suffered from the same problems that psychotherapy was struggling with. That is, it seemed that definitions of medical practice were almost as vague and broad as those attempting to delimit psychotherapy. And the standards for physician licensure seemed to rest on an equally flimsy and empirically unverified base as those being advocated for psychotherapy.

It became clear to me that alternatives to licensure ought to be developed. In addition, it seemed that these alternatives needed to be based on a reconceptualization of the nature of the legal process. Later in my talk this morning, I will present some of these ideas and recommendations. But my more immediate task is to argue as forcefully as possible that licensing is not only ineffective in most professions, including the health field, but perhaps counterproductive.

I do so recognizing several things. First, although eroding rapidly, public and professional faith in the licensing process is still substantial. This means that radical changes in licensing laws are unlikely in the near future. Nonetheless, significant reform is still possible. Second, I am well aware that my position frequently generates antagonism among those who are strong proponents of licensing. I hope that this will not occur today. To minimize this possibility, let me admit something at

the outset. I recognize that my own position is not ironclad. Unfortunately, although I wish it were otherwise, the evidence is neither conclusive enough nor sufficient to warrant high-handed and absolute statements on the merits of the licensing process. I also find it useful to remember that even though I may strongly disagree with others on these issues, all of us share at least one overriding concern - that is, what we are all trying to accomplish today is to find the best way to protect the consumer of health services from incompetent or unethical practitioners. So, our ultimate goal is the same, though our paths to it may differ.

History of Licensing

Let me begin with a brief overview of the history and current extent of professional licensing in this country. The wide use of licensing to regulate professions and occupations is a phenomenon of the twentieth century (Council of State Governments, 1952). In colonial America, even medicine and law were rarely subject to any legal restrictions (Shryock, 1967). In the medical profession the lack of educational institutions or formalized systems of apprenticeship made attempts at regulation difficult. The first medical school was not established until 1765 (Shryock, 1967: 16), and it was not until the 1770s that a law professorship was established at William and Mary (Council of State Governments, 1952: 14).

The earliest laws to regulate directly the medical profession were enacted in Virginia in 1639 (Derbyshire, 1969: 2). Their purpose, however, was only to control the amount charged by practitioners, since so many complaints had been voiced about excessive fees. Ten years later Massachusetts passed a law

regulating "Chirurgeons, Midwives, Physicians or others" who were "employed at any time about the body of men, women or children, for preservation of life, or health" (Derbyshire, in Shryock, 1967: vii). This law marked the first attempt to control quackery in the New World. Those included within its ambit were not to practice "without the advice and consent of such as are skillful in the same Art (if such may be had) or at least some of the wisest and gravest then present." Violators were to be subjected to "such severe punishment as the nature of the fact may deserve." A similar law was enacted by New York in 1665, but neither was enforced, and virtually no further regulation of quackery occurred before 1760.

During the last half of the eighteenth century and the first part of the nineteenth, the newly created states passed a variety of laws licensing physicians and surgeons. One of the prototypes of current legislation was a Maryland law passed in 1798. It created a Medical Board of Examiners, whose principal function was to examine prospective physicians and surgeons (Derbyshire, 1969: 4). As state medical societies gradually came into existence, however, they took over this licensing function.

The question arose whether graduation from a chartered school should not be sufficient in itself to allow one to practice. The matter was first put to the test in 1803 in Massachusetts (Shryock, 1967: 25-26). Harvard's medical school, which had been established in 1783, maintained that its students were as well qualified to practice as those licensed through the Massachusetts Medical Society. Because of public pressure, both groups took an examination, and the Harvard students performed far better than their Medical

Society counterparts. As a result the law was amended to allow the Harvard diploma, as well as the traditional society examination, to qualify one for practice. Similar amendments were soon passed in other states, allowing anybody to qualify for a license who possessed a diploma from a chartered school.

Such charters were easy to come by at this time. The prevailing philosophy of Jacksonian democracy emphasized minority groups, the underprivileged, the poor, and the needy. It advocated a laissez-faire policy that allowed citizens to do whatever they wanted. The doctrine was one of caveat emptor. It did not take long to apply this philosophy to the professions. Proprietary medical schools were established that offered only the lowest quality of education and granted degrees with impunity. Since the populace had become upset with the restrictive practices and attitudes prevalent in the medical societies, a strong movement was made to abolish or amend many of the licensing acts that had been passed. This movement met nearly complete success. By 1845 eight states had never enacted any licensing laws whatever, and ten others had repealed earlier legislation. By 1849 only New Jersey and the District of Columbia had laws that even hinted at adequate regulatory arrangements. Thus, by 1850 the practice of medicine was open to virtually anyone who desired to hang out a shingle. A similar deterioration in licensing laws occurred in the legal profession as well, where two-thirds of the states had abolished all regulations for admission to the bar by 1840, and many were advocating the abolishment of the legal profession altogether (Shryock, 1967: 30-31).

Many historians have evaluated this period as marking one of

the low points in U.S. medicine. At a time when educational standards were low, when so many quacks were allowed to practice, and when regulatory controls were so ineffective, arguments supporting such an evaluation seem persuasive. Nonetheless, several prominent authorities, particularly Kett (1968) and Shryock (1967), make an excellent case for the opposite point of view. Shryock points out that, bad as much of the education was, most regular practitioners in the towns, and close to 50 percent of all rural practitioners, had received some sort of formal training by 1850. This compares with an estimate for Virginia in the eighteenth century of about 11 percent (Shryock, 1967: 107), and is rather remarkable in light of the fact that most doctors had received no formal training whatever only fifty years previously. Shryock cites comments made by leading practitioners and medical school faculty of the time that suggest that the average medical practitioner of 1830-1850 was actually better trained than ever before.

State medical societies, however, became increasingly distressed at the lack of standards and the poor quality of many proprietary schools. Their attempts at securing effective state regulation had failed, but they had not given up hope. Largely out of this concern, the various state societies formed the American Medical Association in 1847 (see Garceau, 1941; Hyde and Wolff, 1954; Rayack, 1967; for a detailed history of the formation of the AMA). At first its efforts were notably unsuccessful. The AMA misjudged the strength of various vested interests and set standards far higher than warranted, given the shortage of physicians and the lack of sufficient high-quality

educational institutions. Reform was also made more difficult because of internal disagreements within the profession itself, especially since many members served on the faculties of proprietary schools and had a vested interest in maintaining low standards.

Eventually, however, the AMA began to have an impact. In 1873 Texas passed a law establishing a state examining board, and by 1895 nearly all states had such legislation (Derbyshire, 1969: 6). During the twenty-five-year period from 1875 to 1900, a gradual effort was made to improve standards. As opposed to early regulatory arrangements, state laws did not vest direct control of licensing in either the societies or the medical schools, but restricted it to the examining board. The medical societies, however, continued to wield significant influence through their sometimes legislatively mandated power to nominate or select those who were to serve on the board.

The turn of the century marked an important period in the development of licensure laws. National associations of all sorts had begun to rise in this country during the mid-nineteenth century (see Gilb, 1966: 17). The power of such organizations was greatly enhanced by the rapid expansion of the railroad and the improved means of communication brought about by the telephone and telegraph. Through their state and local societies they were able to push through licensure laws at an ever-increasing rate. Between 1911 and 1915 alone, 110 statutes licensing twenty-four occupations were enacted. In medicine licensing became mandatory in every state by 1900, and twenty-two required both a diploma from a medical school and successful passage of an exam (Shryock, 1967: 54-55).

Today another surge of licensing laws has occurred. As of 1950, 73 occupations were licensed in one or more states, with 13 licensed in every jurisdiction (Council of State Governments, 1952). The passage of legislation has been so rapid since 1950, however, that twenty years later the health field alone licensed thirty different occupations, with twelve regulated in all states (USDHEW, 1971). This trend has continued unabated. Despite an HEW recommendation for a moratorium on licensure, which was supported by a variety of professional associations, nearly thirty new laws were enacted in the health field in 1974 (USDHEW, 1975). According to a 1969 Department of Labor study (USDOL, 1969), for all professional and occupational groups almost 5,000 different licenses are granted across the country. This covers more than 500 occupations and averages out to 100 per state. California and Illinois are the leading regulators, licensing more than 175 occupations each.

Needless to say, the impact of licensing on the economy is substantial. As of 1976, licensing laws were estimated to affect directly a third to a fifth of the work force (Behavior Today, 1976). According to the Department of Labor 25 percent of the employed labor force in some states is composed of licensed practitioners (Business Week, 1977: 127), and as of 1969, roughly 10 percent of the national income of the United States orginated in occupationally licensed labor markets (Carroll and Gaston, 1977: 2).

Seemingly few groups are not licensed in one state or another. The following sampling from a Department of Labor study (USDOL, 1969; Appendix C) illustrates what I'm talking about. DOL lists, among other groups, aerial horsehunters, athletic exhibition agents,

alligator hunters, astrologers, bedding cleaners, ice cream buyers, cactus plant agents, rainmakers, and photographers as but a few of the occupations requiring a license to practice.

The question, of course, is whether and at what cost this extensive web of regulatory laws has fulfilled its intended purpose of protecting the public's health, welfare, safety, and morals. My examination of the relevant research suggests that licensing may have failed us. Let me briefly summarize the main points of my argument. In the first place, I would maintain that licensing has not accomplished its stated purposes. There is little evidence to suggest that the quality of professional services has improved as a result of licensing laws, disciplinary actions are woefully inadequate, and the prevention of illegal practice is generally spotty, often being aimed at eliminating competition, rather than incompetence.

In the second place, even if licensing laws do assure competent practitioners, an excellent argument can be made that the price is not worth it. The increased cost of services, the creation of shortages in supply, and the development of maldistributions of professionals resulting from licensing laws lead to direct harm to the public through the inability of the poor and other disadvantaged groups to afford or find any pratictioner at all. Frequently such persons resort to injurious self-help, as I will document below. Quite apart from these more obvious costs, the entry requirements of licensing laws have a tendency to discriminate against the poor, the aged, women, and minorities, as well as inhibiting important innovations in the methods of organizing and delivering professional services.

In the third place, even if the net benefits of licensing outweigh the costs, an argument can be made that equally beneficial alternatives are available that are less expensive. In addition, other factors than licensing may be far more influential in determining the quality of service ultimately received by the public, and it is these factors that should be looked to if sound regulation is desired.

What is the evidence for each of these propositions? To ensure that quacks and charalatans are kept out of the field, licensing laws generally require applicants to meet certain educational standards, to have a certain amount of experience, to complete a written or oral examination, and to fulfill various other requirements such as citizenship and residency.

The impact of these requirements on the level of practitioner competence has never been demonstrated (Kessel, 1970: 273), and direct empirical research on this question is relatively unavailable. Substantial indirect evidence exists, however, to indicate that licensing has done little to improve quality. As a starting point, the considered judgments of professionals may be looked to. Forgotson and Cook (1967), who served as consultants to the President's National Advisory Commission on Health Manpower, do not feel that licensure is particularly effective. In the dental field nearly half of all dental school deans and almost 40 percent of all professors believe that licensing boards are not accurate in their assessment of an applicant's ability (American Council on Education, 1961). Even the American Medical Association (AMA, 1971: 30), in a statement approved by the House of Delegates in 1971, concluded that:

> Possession of a license in itself does not directly bear upon professional competence .... In its bureaucratic context, licensure lags well behind the state of current practice ... [and] [a]s an organizational process, it is costly and difficult to implement and continuous surveillance of standards is negligible.

Roughly a fourth of all medical boards do not believe they adequately screen out inept practioners (Dornette, 1976: 9-10). And a former president of the American Medical Association (Rouse, 1968: 72) has written that most board-prepared examination questions "offer few clues to a physician's competence to practice medicine."

A more objective measure of the quality of practitioner performance is provided by empirical studies. The medical field is one of the few areas in which such studies have been done, despite the difficulties involved in defining and measuring "quality." On the whole, the findings indicate that practitioners are not as competent as the public would think.

Illustrative is the research of Osler Peterson and his associates (1956), who studied the quality of care delivered in the private office of a typical North Carolina general practitioner (GP). Expert evaluators directly observed eighty-eight GPs in their daily practice for an average of three and one-half days each. They found only 9 percent of the physicians took reasonably thorough histories and were adequately skilled at interviewing. In the giving of physical examinations the GPs were also seriously

deficient.

Nearly a third of all doctors did not recognize emotional problems of any sort, while more than half recognized them but did not attempt psychological treatment or treated the physical aspects only. Only 17 percent both recognized and treated emotional problems suitably. In conclusion, less than one physician in thirty carried out an adequate physical examination.

Evaluating the available research, Ralph Nader's study group (McCleery, 1971: 153) on the quality of care provided by physicians concluded:

> As a premise for judgment of the present quality of care and of the quality control system, the study asked only whether or not a patient being treated by any physician in his office or hospital can be reasonably sure: that his physician is reasonably competent to treat that ailment (or that the physician will refer him to another physician whom the first believes to be reasonably competent); that his physician is reasonably up-to-date on diagnostic and treatment techniques, and on drug therapy information; that his physician will keep such records as to afford reasonable assurance that his work can later be effectively evaluated; that his physician's performance, no matter where given, will be monitored with reasonable frequency, objectivity and expertness by his peers.
>
> We are forced to conclude that a patient cannot be reasonably sure.

Two other lines of attack may be used to question licensing requirements. First, evidence does not exist that licensing requirements measure factors related to competent performance. A wide range of research indicates that academic grades predict nothing but future grades or results on tests similar to those used in establishing grades (McClelland, 1973). Even ability in highly intellectual and technical jobs such as scientific research cannot be predicted by grades in college (Taylor, Smith, and Ghiselin, 1963). A Labor Department study found correlations between years of education and job performance in only three of twenty cases (USDOL, 1970). Lois Crooks (1977: 4), a senior research psychologist at the Educational Testing Service in Princeton, conducted a sophisticated path analytic study of admission procedures to MBA programs and concluded, and I quote: "Traditional admission criteria such as undergraduate grades and admissions test scores, while they are related to success in graduate school, have no relation to success in business careers."

Even in the medical profession, grades in medical school appear to be unrelated to later performance as a doctor. Price, Taylor, Richards, and Jacobsen (1964), for example, used information obtained from a population of about 500 doctors to determine what constitutes a "good" physician. When the criteria involved were applied to a group of highly competent practitioners, the authors found that "performance in formal education, as measured by grade-point averages, comes out as a factor almost completely independent of all the factors having to do with performance as a physician" (p. 208).

A second line of attack has to do with the methods of testing

that are currently used to determine whether an individual is qualified to practice. Most licensing exams are usually written, requiring extensive recall of a wide range of facts that may or may not be important to good practice. Even standardized national examinations have not been shown to have anything more than face validity. For instance, while the National Board of Medical Examiners examination tests clinical skills and diagnostic judgment, I don't yet know of any research documenting that higher scores on the examination means one is a better physician.

Even if one grants that licensing laws have increased the level of service provided by individual practitioners, the cost may not be worth it. Apart from the negative side effects that I will subsequently discuss, licensing laws may actually cause harm by encouraging injurious self-treatment or by forcing some to go without help altogether. Evidence for this proposition exists. Carroll and Gaston (1977: Appendix V: 8) have found that states with strict laws regulating plumbers have more people doing their own plumbing, as measured by per-capita retail sales of plumbing supplies. Where entry requirements for real estate brokers are strict, they found that houses tended to stay on the market longer (Appendix I). More shockingly, as it were, they also discovered that accidental electrocutions were directly related to the restrictivness of a state's licensing laws for electricians. In fact, in the seven most restrictive states, up to ten times more accidental electrocutions occurred (Business Week, 1977: 128).

Even if the net benefits of licensing outweigh the costs, an argument can be made that licensing is still not to be preferred if an equivalent investment in another method of regulation would

achieve superior results or result in less harm. This may very well be so. Milton Roemer (1970) has pointed out that certain factors such as the maintenance of a safe and hygienic environment, an educated public, and an adequate supply of physical and human resources are essential for minimal quality in health services. Without these factors no amount of physician competence makes much difference.

Given this fact, the general level of the public's health may be improved more effectively by spending an equivalent investment in promoting an adequate supply of physicians and paraprofessionals. Alternatively, other methods of regulation may be available that are equally effective, but result in less cost. Again, Roemer (1970) lists a variety of regulatory mechanisms, including laws regulating hospitals and other facilities, control of drugs and appliances, and comprehensive health planning.

Moving on to the matter of disciplinary enforcement, it is clear that here too licensing boards have generally failed to do what they are supposed to. In the legal field, for instance, after three years of intensive study, the Special Committee on Evaluation of Disciplinary Enforcement of the American Bar Association (1970: 1) reported "the existence of a scandalous situation that requires the immediate attention of the profession." They concluded that "Disciplinary action is practically nonexistent in many jurisdictions ... [and] many disciplinary agencies have little power to take effective steps against malefactors." To give you an idea of the lack of enforcement, only 357 of the nation's 380,000 practicing lawyers were disciplined in 1972 (Nader and Green, 1976: 48).

In the medical field the situation is not much better. The Department of Health, Education, and Welfare (USDHEW, 1971: 33) reported to Congress that "disciplinary action by medical boards is almost insignificant in terms of the universe of practicing physicians [and the] data indicate a tendency toward leniency even in the relatively few cases that result in formal board action." These statements are more than borne out by the data. Using the files of the Federation of State Medical Boards from 1963 through 1967, Derbyshire (1969) found only 161 license suspensions and 334 revocations in a universe of some quarter million physicians. Nearly 50 percent of all actions were for narcotics violations, which were also actionable under existing criminal law, making board action somewhat redundant.

Data published by the AMA's Department of Medical Ethics (1970) provide an even more incriminating picture. In 1969, for example, 33 states did not revoke any licenses. Interestingly, California alone accounted for a third of all revocations, and the total number of revocations was 25 percent less than 1963. Also worthy of note, the AMA ceased publishing surveys of disciplinary enforcement in 1969 (AMA, Office of the General Counsel, 1972). And although Derbyshire, who has been an officer of the Federation of State Medical Boards, was allowed to publish data on disciplinary enforcement of physicians, my request for similar information was denied by the secretary of the board on the basis that such information was confidential (Crabb, 1977).

What are the explanations for this lack of enforcement? The argument is often made that disciplinary actions are rare because physician competence and ethics are high, but this is unlikely.

Jervey (1961: 85-90), for example, estimates that 2 to 10 percent of all physicians are involved in unscrupulous, unethical, delinquent, or incompetent activity. This translates into 7,500 to 35,000 practitioners. Most of us are also aware of Chief Justice Berger's accusations that roughly half of all trial lawyers appearing in federal courts are incompetent to practice.

There are clearly many practical reasons why licensing boards have been unable to carry out their functions. These include lack of adequate funding, inadequate professional staff, vagueness and lack of specificity in the disciplinary provisions of the law itself, and the tendency of licensing boards to wait for the public to report disciplinary problems, as opposed to seeking them out proactively through the use of newspaper clipping services and the like.

Other reasons exist why licensing boards have not been as active as they might be. Jerome Carlin (1966), both a sociologist and lawyer, conducted a fascinating study of the New York City Bar in order to assess the moral integrity of the legal profession. He attempted to establish why some ethical violations led to more severe sanctions than others and why many apparent violations never met with any action. The kind of charge brought proved to be important: lawyers who violated the ordinary ethical standards of the layperson were more likely to be caught and severely punished than lawyers who violated norms unique to the legal profession. In addition, three other factors correlated positively with degree of punishment: (1) the amount of money involved in the offense; (2) the number of acts of misconduct; and (3) the extent to which the violation received publicity or notoriety.

His conclusion (Carlin, 1966: 161-162) is worth quoting in detail:

> The organized bar through the operation of its formal disciplinary measures seems to be less concerned with scrutinizing the moral integrity of the profession than with forestalling public criticism and control....
>
> Further evidence that the organized bar is responding primarily to a concern for preserving its public image is the considerable importance of the visibility of the offense to the general community....It is consistent...with a desire to avoid lay interference and control that the most widely publicized violations would be the most severely and publicly sanctioned. Failure to punish visible violations might result in public criticism of the bar, and the visibility itself offers the profession an opportunity to demonstrate to the public that it can discipline its own members....

The third purpose of licensing laws is to prevent unlicensed practitioners from hanging out a shingle. It is difficult to determine their effectiveness in this regard. The very presence of the law may deter some unlicensed practitioners, especially for practices that are highly visible and easily documentable, such as surgery. For professions in which it may be difficult to prove that somebody is practicing illegally, as in the field of psychotherapy, licensure is unlikely to be a deterrent.

Evidence of effectiveness in this area is scarce, but

Derbyshire (1969: 105-117) - one of the leading authorities on medical licensing - does not believe that licensing requirements pose much much of an impediment for charlatans. He recounts numerous examples of how imposters have functioned for long periods without being detected. Their eventual exposure is frequently a matter of accident, and most do not even bother to forge a license.

Lieberman (in Nader and Green, 1976: 107-111) narrates a number of instances in which bar associations have sought to enjoin real estate brokers and others from performing simple tasks that do not require a great deal of expertise and that are in fact performed competently, but which the bar claims constitute the illegal practice of law. In a recent case, a typist who prepared divorce papers for indigents was brought to court on these grounds (Public Citizen, 1978). It did not matter that the indigents had no other source of legal assistance, and despite her apparent competence, the bar took action, apparently because her charge for services was only one-seventh of what a lawyer would charge. One possible interpretation of this behavior is that licensing boards may be defending the profession against competition, rather than defending the public against incompetence.

A good argument can be made that incompetent or unethical practice is better prevented by other means than licensure. A study of the history of medicine indicates that quacks flourish when physicians are scarce or when their remedies are ineffective. If so, then licensing laws may tend to exacerbate the problem since they further restrict the supply of practitioners. In The Medical Messiahs, James Harvey Young (1967: vii) asserts that health

quackery is more rampant now than ever before. According to him, quacks and charlatans made as much as 2 billion dollars from innocent clients in 1967. This was more than the amount spent on medical research in that year. The extent of such quackery indicates that licensing laws may be relatively ineffective in controlling it.

Even more damaging, I would argue, are the negative side effects that licensing may be producing. First of all, licensing laws exacerbate shortages in the supply of practitioners. While little research exists on this point, the influence of licensing seems obvious, especially since its explicit purpose is to limit supply to those deemed qualified to practice. If entrance criteria are in any way arbitrary, or if other aspects of the administration of licensing laws unnecessarily restrict the number of practitioners, then licensing will obviously have a needlessly restrictive impact. My discussion of the overemphasis on academic credentials and the use of unvalidated tests provides one line of support for this argument.

Other evidence can be martialled, however. Licensing laws are meant to ensure only minimal levels of competence, not that all practitioners are expert in their trade. Yet, many laws, especially those requiring advanced graduate degrees, are clearly aiming at a higher level of competence. In fact, professional associations, in drafting and then lobbying for particular laws, often argue that the required credentials are necessary to ensure the highest quality of service. The variability of requirements in the same profession over a number of states and the tendency of requirements to become more stringent over time despite a notable lack of evidence that the required competencies have changed, both indicate

that unnecessary restrictions are being placed on many fields of practice.

As for empirical support, Rayack's (1975: 147) careful research on a number of licensing agencies in southern New England led him to conclude, and I quote: "When labor market conditions worsen, licensing boards tend to fail a higher percentage of applicants for licensure, irrespective of the qualifications of the applicants, in order to reduce the flow of new entrants into the market and thereby strengthen the competitive position of the licensed" (see also Maurizi, 1974). Carroll and Gaston's (1977: 41) NSF-supported study of eight diverse professions found that restrictive licensing significantly lowered the number of people licensed, and there was some evidence that such restrictions actually lowered the quality of service received.

Attempts to verify empirically the restrictive effects of regulation in other areas may have some generalizability to the field of professional licensing. Stigler and Friedland (1962) examined electric utilities and found that laws designed to curtail the exercise of monopoly power and to eliminate price discrimination were totally ineffective in achieving their purpose. Another study by Demsetz (1968) indicates that regulation drastically decreased the number of public utilities. In the airline industry, Jordan (1970: 16-17) notes that the only carriers providing trunk service as of 1970 were those that existed when the Civil Aeronautics Board was formed in 1938. In California, however, where the CAB does not have jurisdiction, sixteen intrastate carriers entered the field in the twenty years up to 1965. After reviewing these and other studies, Jefferey Pfeffer (1974: 478) at the University of California at Berkeley has concluded that:

> The role of administrative regulation in the solution of social problems must be called into question. There is evidence that administrative regulation and licensing has actually operated against the public interest; and that rather than protecting the public from the industry, regulation has frequently operated to protect and economically enhance the industry or occupation.

Licensing laws also exacerbate maldistributions in the supply of practitioners. This is especially the case where licensure laws make it difficult for licensed practitioners in one state to obtain a license in another. Florida, for instance, has been notorious for its stringent and arbitrary requirements for out-of-state physicians. These constitute a direct attempt to discourage semiretired practitioners from moving to the state, since they pose an economic threat to those doctors already practicing. Wide variations in licensing examination policies have also hampered the movements of practitioners from state to state, especially those attempting to be licensed for the first time. This problem has diminished as more states adopt national examinations.

Broad and overly vague definitions of professional practice, when combined with stringent supervisory requirements, also foster maldistributions. Effective use of paraprofessionals in rural areas, for example, is dependent upon the elimination of "over-the-shoulder" and "on-the-premises" supervision, since such requirements are impractical and eliminate the substantial value of paraprofessionals making house calls, as is the case with midwives.
In addition, definitions of practice need to be narrowed or exemptions provided so that paraprofessionals can undertake certain

types of carefully and narrowly prescribed medical diagnoses and treatment.

Rigorous empirical research on the tendency of licensing laws to create maldistributions is woefully inadequate, but the majority of studies indicate that the effect is significant. Fifteen years ago, Arlene Holen (1965) studied the interstate mobility and resource allocation of dentists, lawyers and judges, and physicians and surgeons. In the case of physicians, where reciprocity agreements were common, she found much greater interstate mobility (as reflected by migration rates) and resource allocation (as reflected by differences in professional incomes by state) than for dentists and lawyers. A more recent finding by Holen (1977), however, demonstrates that those states with more stringent requirements have actually had a greater increase in dentists per capita over the last ten years. Holen suggests that this occurs because the income of dentists is higher in those states with more stringent requirements, which attracts more and better-qualified applicants.

On the other hand, a study by Shepard (1978) in the Journal of Law and Economics, documents the various means that licensing boards use to exclude out-of-state practitioners. He estimates that these methods have resulted in a 15 percent increase in dental fees nationwide and an overall cost of approximately 700 million dollars. Shepard cites findings that the 35 dental boards that do not have reciprocity agreements with other states fail an average of 22 percent of recent dental school graduates from out of state, versus a mean figure of 9 percent in states with reciprocity. These same states granted significantly fewer dental degrees to students in their own states, as well.

A third harmful effect of licensing is to increase the cost of professional services. Lee Benham (1972), for instance, has found that in states prohibiting advertising related to eyeglasses and eye examinations, prices for these items were 25 to more than 100 percent higher than states with no restrictions. Qualitative evidence suggested that other factors were not creating a spurious relationship. An FTC study by Phelan (1974) adds support to this thesis. He examined the cost of TV repairs in New Orleans, San Francisco, and Washington, D.C. Louisiana has a strict licensing law requiring two years of formal training or two years of apprenticeship and successful completion of a written exam. California allows anyone to practice so long as she or he is registered with the state, but has a very active disciplinary board. And Washington, on the other hand, has no law whatever. The cost of repairs was significantly higher in New Orleans, while the variation in costs was significantly less in San Francisco. Interestingly, fully half of all repairs involved fraud in New Orleans and Washington, while the rate in California was only 20 percent.

Shepard (1978) has analysed licensure restrictions and their relationship to the cost of dental care. He found that fees for eleven of the twelve most common services were higher in states that lacked reciprocity agreements with other states. These differences were statistically significant in more than half the cases, even when accounting for regional cost-of-living variations. Holen's (1977) research on the same subject, however, explains this finding on the basis of better dental care being provided.

I'd like to draw one last example from the airline industry.

Michael Levine (1965) has written an interesting article in the Yale Law Journal about the impact of the Civil Aeronautics Board. As I mentioned before, the CAB does not have intrastate jurisdiction, so Levine compared transportation between L.A. and San Francisco with interstate travel across the rest of the country.

Traffic between San Francisco and L.A. increased almost 300 percent between 1959 and 1964, although traffic in the United States as a whole rose only 50 percent. The cost per mile of travel in California was only 3.9 cents, versus 5.5 cents for average jet coach fare in the United States. Air fare between Boston and Washington, which involves interstate traffic and a distance roughly equivalent to the Los Angeles-San Francisco trip, cost more than twice as much.

The problems and horrors of lack of regulation did not occur. No disastrous competition and price wars ensued. Despite the fact of reduced rates, firms were able to operate profitably. Small, local airlines were able to compete with the larger established airlines. Even the expected increased risk to passenger safety did not materialize. Levine (1965: 144) notes that Pacific Southwest Airlines had not experienced a fatal accident up to the time of his study, and Trans California, the most recent intrastate entrant, had no safety problems whatever during the two years it was in operation.

Levine's (1965: 1416-1417) conclusions are worth quoting in full. He says:

> Government restriction of entry into the industry and the regulation of fares has fostered unnecessarily high fares, encouraged uneconomic practices, and limited the variety of service available to the

> public. The performance of the largest air transportation market in the world provides convincing evidence that fares are much lower and service more responsive to public needs where restrictions on entry are absent and control over fares is rarely exercised.

So much for the increased cost of services. Another harmful side effect of licensing is the ineffective utilization of paraprofessionals that it encourages. Perhaps the most serious problem has been its tendency to restrict the number of auxiliaries available to practice. By defining in extremely broad terms those practices restricted to fully licensed practitioners, and by making no provision or very rigid and narrow provisions for delegating functions to others, licensing laws unnecessarily limit paraprofessionals. In their report to the National Advisory Commission on Health Manpower, Forgotson, Roemer, and Newman (1967: 332) stated that "among the many problems presented by the medical licensure laws, without question, the issue of delegation of tasks is a highly significant, if not the most significant, problem requiring resolution."

Educational requirements and other prerequisites for obtaining a license seriously restrict the number of paraprofessionals able to practice. Many requirements are unrelated to ability, especially citizenship, residency, age, and other personal requirements. The amount of schooling and experience demanded is often excessive. Many of the laws regulating the paraprofessional do not allow alternative routes to licensure, such as through equivalency or proficiency testing, or through giving credit for related work experience. Often no credit is allowed for formal

education in a degree program different from the one licensed, even if the courses are identical - a fact that has serious implications for career mobility. Egelston (1970: 44) comments: "The increasing number of allied health groups seeking licensure ultimately will create job overlap and increase the number of dead-end jobs. Moreover, it appears predictable that a proliferation of licensing laws eventually will require multiple licenses for practitioners."

Data collected by Arnhoff (1971: 73-77) indicate that paraprofessional training programs in the military require far briefer time commitments without necessarily sacrificing quality. For instance, where civilian programs require dental specialists to be trained for 2 years, the military requires only 16 weeks. A similar differential exists for X-ray specialists. Dental assistant programs located in technical institutes and hospitals almost always are less than a year in length, while almost 50 percent of those located in universities and hospitals require more than 71 weeks.

Licensing laws also hinder paraprofessionals once they are on the job. Overly broad definitions of practice for the fully licensed practitioner prevent auxiliaries from performing many tasks of which they are fully capable. Lave and Lave (1970: 257-260) estimate that 80 percent of pediatric practice could be done by personnel with far less training. The typical medical practice act allows only the physician to diagnose, operate, treat, or prescribe for mental or physical illnesses. Paraprofessionals are granted limited and circumscribed fields of practice.

It is difficult to know what the limits of the physician's functions are The result is that most physicians are hesitant to

allow paraprofessionals to perform questionable tasks unless a legal determination has been made that performing a particular task will not be in violation of the law. Ruth Roemer's (1970: 48-49, footnotes omitted) analysis of the problem is worth quoting in detail:

> As for specific prohibitions in the statutes or regulations, one may take the example of providing medication. The medical practice acts stipulate that only physicians may "prescribe" or "furnish" drugs; the pharmacy laws authorize pharmacists to "dispense" drugs; and the nursing practice acts authorize nurses to "administer" them. The question is: what acts constitute "dispensing," and what acts constitute "administering"? This is not a matter of semantics but a practical question affecting behavior of health personnel.
>
> Interpretations of the pharmacy law in some states are so restrictive that nurses refuse to issue routine refills of prescriptions in the absence of standing orders or telephone prescriptions from a physician. Thus, in Los Angeles County, public health nurses were concerned about their authority to provide continuing medication in an isoniazid therapy program of tuberculosis control. A night nurse on duty in a small hospital without a pharmacist at night may be acting in a grey area between medical and nursing practice if she issues

medications.

> ...It is significant that the medical licensure laws were enacted in the late 1800's and early 1900's when the provision of medical care was vastly different from that in the current health system. Licensure laws for other health professions and occupations were patterned after the medical model. What may have been proper when medical care was largely provided by solo practitioners in an entrepreneurial fashion may no longer be reasonable when medical care is increasingly a product of team effort in an organized setting, rather than of an individual practitioner. Between 1900 and 1967, physicians declined from 35 percent to 9 percent of the total supply of health manpower. Yet no significant amendment of any state medical practice act has been made in nearly a century, and the definitions of scope of functions in the various licensing laws have now become a straitjacket on delivery of services by a health team.

Until recently no medical practice acts explicitly provided for the delegation of functions to allied health personnel. Such delegation was simply a matter of prevailing custom and practice. This situation has changed substantially in the last twelve years as a result of various amendments to the medical practice acts (Sadler, 1974; Willig, 1971). These amendments have basically taken two forms (Howard and Ball, 1973). In one, the medical practice act codifies the legal right of the physician to delegate tasks

to certain qualified nonphysicians. The second involves a completely separate licensing law for the auxiliary personnel. Despite some improvement in the amount of delegation allowed, auxilliary personnel are still not allowed to perform functions of which they are capable, and the degree of supervision required is often excessive.

Another more subtle impact of licensing laws is to inhibit improvements in training, education, professional practice, and the way in which services are organized. The primary manner in which training and education are restricted is through licensing board requirements that applicants be graduates of "accredited" programs. This would not be a problem if accreditation meant that a program produced qualified practitioners, but no such evidence exists. Rather, accreditation focuses on the quality of education provided, and it is assumed that traditional methods of education produce competent practitioners. Typical concerns center around student-faculty ratios, the number of classroom and other facilities, and faculty background and training (Newman, 1973).

The lack of thoroughness that characterizes much of what passes for accreditation also indicates that accreditation may not be doing its job. Even the inspection of medical schools carried out by Abraham Flexner in the early part of this century was somewhat cursory. Taylor and Torrey's (1972) study of accreditation in the mental health field illustrates how casual the accreditation process can become. In psychiatry, accreditation is the function of the Joint Residency Review Committee for Psychiatry and Neurology, which consists of six psychiatrists. The committee meets

only twice a year, and does so in private. It typically acts upon as many as 100 separate programs. The evidence on which a determination is made consists of written applications and the additional comments of field staff, who usually inspect at least two programs in a normal workday and sometimes as many as four or five. The written application asks for information that has virtually no relevance to the quality of the training provided, inquiring about such anachronistic data as the number of consultants available in tuberculosis, anesthesia, and urology. Taylor and Torrey (1972) conclude:

> The most damaging aspect of this current system of training program accreditation is its destructive influence on the evolution of psychiatric education. Training programs, in order to ensure continued approval, must conform to rigid requirements. Experimentation in developing psychiatric manpower that is more relevant to the public need must be curtailed in order to maintain an accreditation upon which federal support is dependent (p. 661).

As for restrictions on professional practice and the organization of services, Jethro Lieberman (1978, 1970) has done much to demonstrate the negative impact of licensing. These restrictions generally occur through the use of the disciplinary provisions in licensing laws. For example, they have been used to curb the development of comprehensive prepaid group medical plans in the health field (Kessel, 1970), as well as the development of low-cost clinics in the legal field.

The noted medical authority Harold Jervey (1971: 91-92) has described the problem well. He writes:

> What of the laws governing the practice of medicine in the various states? Sir William Osler in 1902 said, "Our medical licensing system is provincialism run riot and is in a pestiferous condition." Unfortunately the libretto may have changed slightly with the passage of time, but the tune has remained essentially the same. The most recent studies done by such prestigious groups as the President's Health Manpower Commission and the Coggeswell Report and others have indicated that the state laws are impeding not only medical education but everything medical including the distribution and delivery of health care.

Milton Friedman (1962: 157) is probably also worth quoting on this point. He emphasizes, and I quote:

> There are many different routes to knowledge and learning and the effect of restricting...practice ...and defining it as we tend to do to a particular group, who in the main have to conform to the prevailing orthodoxy, is certain to reduce the amount of experimentation that goes on and hence to reduce the rate of growth of knowledge in the area. [Friedman, 1962: 157.]

The last problem created by licensing laws is their tendency to discriminate against minorities, women, the aged, and the poor. The lack of women and minorities in the professions is well known. To give but a few illustrations, less than 10 percent of all

physicians (AMA, Center for Health Services Research and Development, 1977: 11, 35) and only 11.4 percent of all psychiatrists (American Psychiatric Association, 1973: 3) are women. Blacks make up only 1.4 percent of all psychiatrists (American Psychiatric Association, 1973: 5) and 4.3 percent of all physician assistant graduates (Hiestand and Ostow, 1976: 77).

The extent to which licensing laws are responsible for the absence of these groups from the professions is difficult to determine. Little convincing research has been done on this, but common sense and indirect evidence suggests that this proposition has some validity.

In essence the argument for the existence of discrimination is rather simple. It runs as follows. If academic credentials are required for entry into a profession, and if these credentials are not valid or reliable measures of competence, and if minorities, women, the poor, and the aged have greater-than-normal difficulty in obtaining these credentials, then it is reasonable to assume that discrimination has taken place (whether intentional or not). White and Francis (1976) have provided convincing arguments with supporting data to indicate that this is the case. They first point out that a major determinant of who completes high school, who enters college, and who graduates with a college degree is socioeconomic class. Since minority groups constitute an abnormally high percentage of the poor, and more than twice the percentage of blacks than caucasians leave high school without graduating, the prerequisite of academic achievement becomes a powerful force for racial discrimination.

Credentials also operate against women. White and Francis (1976: 1223) point out that in 1968, 14 percent fewer women than

men in the eighteen- to twenty-four-year-old age bracket went on to college after high school graduation. The percentage of doctorates awarded to women has not increased substantially since 1900, when it was 9 percent, despite the fact that women receive superior grades in both high school and college. Other evidence indicates that academic admission policies have favored men over women, even when both have identical qualifications.

A final group that White and Francis (1976: 1225-1226) argue are discriminated against by credential requirements are older men and women, since earlier generations left school with fewer credentials than the average student today. In fact, by 1980 half of the U.S. labor force will be composed of individuals under thirty-five with at least four years of college. On the other hand, half of the workers with no more than an elementary school education will be over fifty. Most older men and women cannot afford to leave their jobs and go back to school. Thus, the reliance of licensing laws on academic credentials, which are less frequently possessed by the poor, minorities, women, and the elderly, has a deeply pernicious and discriminatory effect, especially when evidence does not exist that these credentials are positively correlated with competence.

According to a number of political scientists, the pervasiveness of licensing and the emphasis of our society on professional certification indicates that the United States is returning to a guild society reminiscent of the Middle Ages (see, e.g., Gellhorn, 1976, 1956; Gilb, 1966; and Lieberman, 1978, 1970). Like the guilds,

licensed professions have established and enforced compulsory membership, creating a monopoly. Like the guilds, licensing standards have become higher and the cost of licensure has increased. Like the guilds, periods of apprenticeships have been lengthened, the number of apprentices has been restricted, and the possibility of licensure through apprenticeship has frequently been eliminated.

Now that I have spent all this time railing against licensing, what system would I propose in its place? First, let me recommend a reconceptualization of what laws and regulation are all about. The prevailing orthdoxy defines the law as a form of social control that comes into being through an exercise of authority. Regulations are seen as a means of implementing restrictions that are enforced by sanctions. This focus on control is a natural outgrowth of the logical positivism that has dominated our legal system for most of this century (see, e.g., Austin, 1954; Kelsen, 1945; and Hart, 1961). It has lead to licensing laws that focus on restricting who can enter a field and disciplining the errant practitioner.

A different conception of the regulatory process is preferable however. Lon Fuller (1969) of the Harvard Law School has argued that the basic purpose of laws is to provide a framework for, and method of, facilitating human interaction. The implication of this definition is that regulations should not only be designed to protect the public, but they must be framed in such a way that they meet the needs of that public. Conceiving of regulation in this interactive fashion helps focus on both the positive and negative impact of licensing laws. It suggests that their over-arching goal ought not to be protecting the public from harm so much as ensuring that the quality, quantity, and cost of services

is improved.

On the basis of the above, let me recommend some specific policy goals that ought to guide the formulation of any set of health care regulations in California. First, I would move away from the goal of attempting to provide the highest quality care to everybody. This goal has characterized much of U.S. health care policy throughout history, but I believe that it is both unrealistic and unworkably expensive. Instead the goal of health care regulation should be the development of an optimum health service designed to provide all individuals, regardless of age, sex, race, or financial situation, with ready access to adequate and nondiscriminatory services at minimal cost. Second, while an important emphasis should go to improving the overall level of health, this should be done without drawing critical resources away from other areas of the economy. Third, the primary focus of health care should be on prevention; and in planning an intervention strategy, appropriate recognition should be given to the multiple causes of illness, including life style and the environment. Finally, every effort must be made to demystify the professions and to encourage client independence, responsibility, and control.

I have formulated a detailed set of recommendations for the mental health field that is in line with the above policies. What I'd like you to consider today is the degree to which these ideas may be applicable to the entire health field, not just the more limited profession of psychotherapy. First, any definition of practice regulating a health care profession should be narrowly and precisely drawn, in sharp contrast to the broad and vague

definitions now in force - the definition of medical practice being an excellent example. Second, standards and criteria to determine who is qualified to practice should be competence-based and related to actual performance. Academic credentials should only be used if they pass this test. Third, alternative paths to certification should be kept open, including apprenticeships, proficiency examinations, educational equivalency exams, or certification by appropriate accredited organizations. In this regard, I would encourage certifying bodies to experiment with peer review, client review, on-the-job evaluations, and the plethora of other ways of establishing professional competence. Fourth, I would place a high degree of emphasis on the training of competent paraprofessionals. Fifth, I would make sure that both the design and administration of regulatory policies and programs should include a balanced representation of appropriate constituencies. Normally, these would involve the public, professionals, government officials, clients, and any other affected parties. Finally, licensing laws should only restrict the use of certain titles, not the right of a person to practice.

It is absolutely essential to recognize that licensing laws are not meant to ensure a high level of professional competence, only that a practitioner is not likely to harm the public. This means that licensing laws should adopt minimum requirements for entrance into a profession, and these requirements should be clearly related to competent practice. In other words, licensing laws should emphasize the regulation of output, not input. Hence, they should be concerned with a person's actual skills, not how those skills were obtained. Since so little is known about the effective training and selection of professionals, a further purpose of

licensing should be to promote a pluralistic system for the delivery of professional services.

My own view is that licensing is probably inadvisable for the mental health field at this time. The question can also be raised whether it is necessary in the health care field as a whole. In its place, I would recommend a system of registration. By this I mean that persons who wanted to practice a given profession would simply have to register with the state, but they would not have to meet specific educational prerequisites or otherwise demonstrate their competence. On the other hand, they should be required to provide the state and any clients with detailed information about themselves in the form of full and public disclosure. This should involve a description of their training, experience, whether and by whom they were supervised, the techniques they use, the expected length of treatment, fees, and the address and phone number of the registration board - to list but a few of the possibilities. The registration board should be empowered to conduct disciplinary hearings and to remove a practitioner from the register for due cause, which would result in persons losing their right to practice. Obviously, this means that such a board would have to be funded adequately and would have to have adequate legal powers, as well as trained staff. I would even like to explore the possibility of clients providing the board with an evaluation of services rendered by professionals. These evaluations could be kept on file for prospective consumers and might be used in disciplinary hearings.

A key element to the success of such a system is proper education of the public. Laws requiring full disclosure on the part of professionals are clearly important, but major programs

of public education need to be undertaken at the same time.

If restrictive licensing laws are to be enacted, I would adopt the following guidelines to determine whether licensing is appropriate. First the profession being regulated must be mature and well-established. Second, it must have a clearly defined field of practice. Third, it must have a significant public impact to justify invoking the state's involvement. Fourth, the net benefits of licensing ought to outweigh any negative side effects. Fifth, less restrictive alternatives must be unavailable. Sixth, the potential for harm from incompetent or unethical practitioners must be significant, pervasive, and well documented. Seventh, reliable and valid measures must exist to determine whether practitioners are qualified to practice. Eighth, adequate financial and human resources must be provided for the operation of the regulatory board or agency.

My published work on The Regulation of Psychotherapists (Hogan, 1979a-d) goes into even greater detail regarding specific recommendations for regulatory reform, but I suspect that most of you have probably reached the saturation point with regard to absorbing further recommendations. What I've tried to do this morning is to point out some of the problems that exist with traditional licensing mechanisms and to suggest some alternatives. As much as possible, I've tried to bring the findings of social science research to bear in my proposals. The evidence is mounting that traditional methods of regulation have not done their job. I hope that my suggestions prove useful to the Board of Medical Quality Assurance and to others of you concerned and involved with the formulation of health policy. And once again, I thank you for the opportunity of speaking before you. Thank you.

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